

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03247

CERTIFICATE OF DEATH

03241

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH

e. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oakland

14 Hours

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Garrett County Memorial Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Dey

Year

Roy

Elmer

Barb

March

26

1962

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

October 4, 1891

9. AGE (In years
less birth day)

70 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 HRS.

Dey

Hours

Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

11b. KIND OF BUSINESS OR INDUSTRY

Own Farming

11. BIRTHPLACE (County & State, or foreign country)

Shenandoah, Virginia

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Alkanah Barb

Lucy Ellen Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

220-10-2954

Walter F. Campbell

Route # 2

Oakland, Maryland

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Acute Myocardial Infarction

INTERVAL BETWEEN
ONSET AND DEATH

12 hours

Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Arteriosclerotic CardioVascular Disease

—

MEDICAL CERTIFICATION

20c. TIME OF INJURY Month, Dey, Year
Hour e.m. 20d. INJURY OCCURRED
p.m. 19 While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

21f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from June 11:23 1959, to March 26, 1962, that (I) (we) last
saw the deceased alive on March 25, 1962, and that death occurred at A.M., from the causes and on the date stated above.

22e. SIGNATURE

Herbert H. Leighton

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED

26 Mar 62

22c. PHYSICIAN'S NAME (Type)

Dr. Herbert H. Leighton

22d. ADDRESS

Oakland, Maryland

23e. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
Burial 3/28/1962 Pleasant Valley Cemetery, Garrett County, Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

H.C. Leighton

ADDRESS

Oakland, Md.

25e. REC'D BY REGISTRAR

MAR 29 '62

25b. REGISTRAR'S SIGNATURE

Clyde S. Thomas

1880



1880-01-08

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03248

CERTIFICATE OF DEATH

Reg. Dist. No. 03242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ACCIDENT</u>	
3. NAME OF DECEASED (Type or print) <u>ALBERT</u>		d. STREET ADDRESS	
4. DATE OF DEATH Month <u>MAR</u> Day <u>15</u> Year <u>1962</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>GARRETT Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB BECKETT</u>		14. MOTHER'S MAIDEN NAME <u>MARY DIELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Frederick Smith, Accident, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion</u>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ATHEROSCLEROTIC HEART DISEASE</u>			
DUE TO (c) <u>Ageing</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Friendsville, Md</u>	
21. I certify that I attended the deceased from <u>1952</u> , to <u>MARCH</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>MARCH</u> , 19 <u>62</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Pedro Rivera</u>		ADDRESS (Street, city or town, state) <u>Friendsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>PEDRO RIVERA</u>		DATE SIGNED <u>3-1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/18/62</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>ST. JOHN'S</u>		22d. LOCATION (City, town, or county) (State) <u>ACCIDENT, GARRETT Co, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman, Grantsville, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Arthur S. Thorne</u>		24b. REGISTRAR'S SIGNATURE	
DATE <u>MAR 20 '62</u>			

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33590 1937A 0780

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03249

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03243

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Altamont

c. LENGTH OF STAY IN 1b

50 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rural Swanton, Md.

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

George Franklin Comp

Month

Day

Year

4. SEX

6. COLOR OR RACE

Male

White

WIDOWED

DIVORCED

NEVER MARRIED

Divorced

MARRIED

Divorced

8. DATE OF BIRTH

July 3, 1889

9. AGE (In years
last birthday)

72 yrs.

IF UNDER 1 YEAR

Months Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Retired Telegraph Operator, B&O R.R. Garrett Co., Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John Comp

14. MOTHER'S MAIDEN NAME

Mary Barker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give rank or dates of service)

no

16. SOCIAL SECURITY NO.

705-05-8225 George Comp

17. INFORMANT

Address

Deer Park, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

420.1
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?
YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE

James H. Feaster, Jr., M. D.

M.D.

DEPUTY MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial 3/28/1962

22b. DATE THEREOF

Deer Park Cemetery

ADDRESS

Oakland, Md.

DATE

MAR 29 '62

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Arthur S. Kimes

VS. AISM
SM 9/60

01920

CASE

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03250 03244

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
Garrett		b. STATE Lives in Maryland Va.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		b. COUNTY Garrett County, Md.	
Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
34 Days		Post Office Route # 1 Gormanian. W. Va.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
John		Last	
4. DATE OF DEATH		Month	Day
Culp		March	11
5. SEX		5. COLOR OR RACE	
Male		White	
6. MARRIED		7. NEVER MARRIED	
<input type="checkbox"/>		<input type="checkbox"/>	
8. WIDOWED		9. DIVORCED	
<input checked="" type="checkbox"/>		<input type="checkbox"/>	
10. USUAL OCCUPATION (Give kind of work done during most of deceased's life, even if retired)		11. KIND OF BUSINESS OR INDUSTRY	
Retired Coal Miner		Soft Coal	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
U. S. A.		Indiana	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)	
Holderman, Mary Catherine		no 232-09-3292	
16. SOCIAL SECURITY NO.		17. INFORMANT	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
42 DUE TO		1 week	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cerebral Vascular Accident	
(b)		Arteriosclerotic Cardio Vascular Disease 20 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Diabetes Mellitus			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 18 61 to March 11 1962 that (I) (we) last saw the deceased alive on March 10 1962 and that death occurred at 4:00 A.M. from the causes and on the date stated above.		22b. DATE SIGNED 11 Mar 62	
22a. SIGNATURE Herbert Leighton		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
Dr. Herbert Leighton		Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		23c. NAME OF CEMETERY OR CREMATORIUM	
3/13/1962		23d. LOCATION (City, town or county) (State)	
Fairview Cemetery		Garrett County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
He. Leighton		25b. REGISTRAR'S SIGNATURE	
		DATE MAR 15 '62 Arthur S. Kraus	

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B697-99-S18

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FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03251

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03245

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Oakland,

c. LENGTH OF STAY IN lb

6 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

6 Mi. So. Oakland,

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Sophrona

Fike

Davis

5. SEX

6. COLOR OR RACE

Female

White

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House work

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Dec. 19, 1884

9. AGE (In years last birthday)

10. IF UNDER 1 YEAR

77 yrs.

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

13. FATHER'S NAME

Amelius Fike

14. MOTHER'S MAIDEN NAME

Elizabeth Glass

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

R. Grover Lee

Address

R. D. #2 Oakland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

Burns, 3rd. degree of entire body

916.0

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED?

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

House caught on fire and occupant did not get out.

20c. TIME OF INJURY Month, Day, Year
3 Hour a.m. 3-20- 62
xx 19

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home

20f. (City or town) (County) (State)
Rural, Oakland Garr. Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

22b. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22c. DATE THEREOF
3/22/1962

23. FUNERAL DIRECTOR

ADDRESS

H.C. Keighton
Oakland, Md.

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

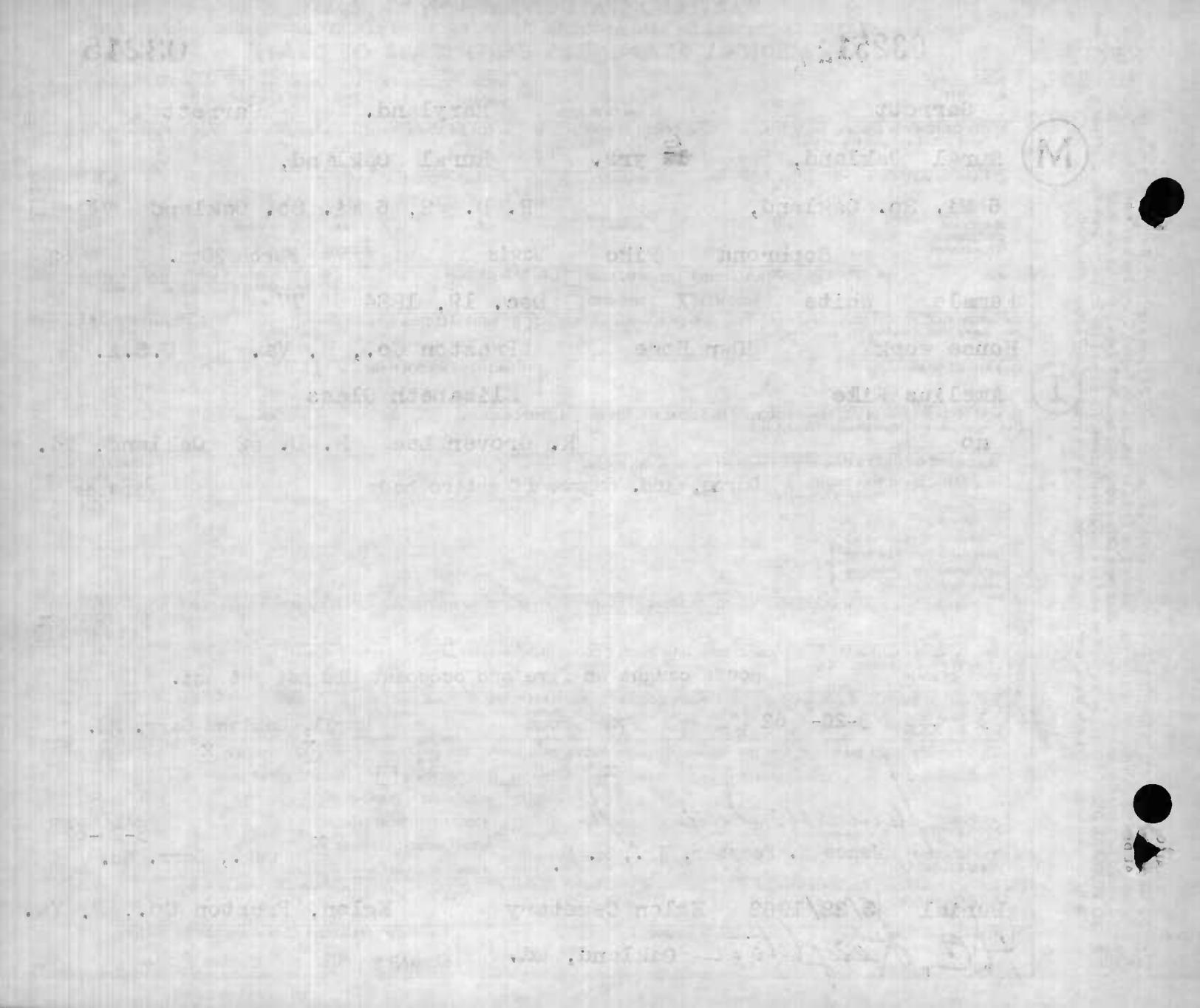
DATE SIGNED
3-20-62

Oak., Garr. Md.

22d. LOCATION (City, town, or country) (State)
Eglon, Preston Co., W. Va.

24e. REC'D BY REGISTRAR DATE
MAR 21 '62

24b. REGISTRAR'S SIGNATURE
Arthur S. Krause



1
 TO HOSPITAL OR
 may be referred to hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G309 3/28/62 ikw

03252

CERTIFICATE OF DEATH

Reg. Dist. No. 03246

1. PLACE OF DEATH a. COUNTY GARRETT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL GRANTSVILLE	
3. NAME OF DECEASED (Type or print) NETTIE		d. STREET ADDRESS	
4. DATE OF DEATH Month MARCH Day 19 Year 1962		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 13 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) GARRETT Co, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CYRUS SPEICKER		14. MOTHER'S MAIDEN NAME MARTHA DURST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Richard Durst, Grantsville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Acute brain syndrome Generalized arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 31, 1960 to Mar 19, 1962 that I last saw the deceased alive on Feb 20 1961 , and that death occurred at 6:00 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 209 North St Meyersdale Pa	
ACTUAL SIGNATURE Leonard L Rockard		DATE SIGNED	
PHYSICIAN'S NAME (Type) LEONARD L Rockard			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/21/62	
22c. NAME OF CEMETERY OR CREMATORIAL DURST		22d. LOCATION (City, town, or county) (State) GRANTSVILLE, GARRETT Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman Grantsville, Md		24a. REC'D BY REGISTRAR DATE MAR 23 '62	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03247

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural McHenry		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural McHenry	
d. STREET ADDRESS		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred		First	Middle
		Last	
4. DATE OF DEATH March 10th.		Month	Day
		Year	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Mar. 26, 1916		9. AGE (In years last birthday) 45 yrs.	10. IF UNDER 1 YEAR Months Days
			11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) McHenry, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Beason Glotfelty		14. MOTHER'S MAIDEN NAME Vinnie Kamp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or dates of service no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Cecil Edgar McHenry, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. DUE TO (c) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO CARDIAC MURAL THROMBUS RHEUMATIC ENDOCARDITIS	
		19. INTERVAL BETWEEN ONSET AND DEATH Sudden	
		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE James H. Feaster, Jr., M. D. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Oak., Md. 3-10-62	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22f. DATE THEREOF 3/13/62	22g. NAME OF CEMETERY OR CREMATORIAL Garrett Co. Memorial Gar. Oakland, Maryland
23. FUNERAL DIRECTOR Gerald N. Minich		24a. ADDRESS Oakland, Maryland	24b. REC'D BY REGISTRAR DATE MAR 16 '62
		24b. REGISTRAR'S SIGNATURE Christina S. Thomas	

1500

22900



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03248

03254
1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Deer Park

c. LENGTH OF STAY IN 1b

12 hours

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First Middle Last

John Ray Evans, Sr.

4. DATE
OF
DEATH
Month Day Year

March 6th. 19 62

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

Aug. 14, 1897

9. AGE (In years
last birthday)

64 yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Washer

10b. KIND OF BUSINESS OR INDUSTRY

Hosp. Laundry

11. BIRTHPLACE (State or foreign country)

Shaffer, W. Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Perry Evans

14. MOTHER'S MAIDEN NAME

Ann Fanser

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

705-10-9046

17. INFORMANT

Minnie Evans Mt. Lake Park, Md.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

420. (b)
Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

INTERVAL BETWEEN
ONSET AND DEATH
Sudden

2. MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY or CONTRIBUTING
CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

19. WAS AUTOPSY
PERFORMED?
YES NO

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER
M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)
James H. Feaster, Jr., M. D.

Address (Street, city, town, or county)
Oak., Md. 3-7-62

22e. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

22b. DATE THEREOF
3/9/62

22c. NAME OF CEMETERY OR CREMATORIUM
Terra Alta Cemetery

22d. LOCATION (City, town, or country)
Terra Alta W. Va.

23. FUNERAL DIRECTOR
Gerald N. Minnich

ADDRESS
Oakland, Maryland

24e. REC'D BY REGISTRAR
DATE MAR 12 '62

24b. REGISTRAR'S SIGNATURE
Arthur S. Krause

3300
M

3300
A

CERTIFICATE OF DEATH

Reg. Dist. No. 03249

1. PLACE OF DEATH a. COUNTY GARRETT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE, Mo.		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X FRIENDSVILLE, Md.		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MINNIE		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH JAN. 15, 1886	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY own Home	11. BIRTHPLACE (State or foreign country) FRIENDSVILLE, GARRETT Co. Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME MILTON RUSH	14. MOTHER'S M AIDEN NAME SAMANTHA Umel	Address Geo. Hileman, Friendsville, Md	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	INTERVAL BETWEEN ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident			
33 IX		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Hypertension, Essential	
		DUE TO	
		(c) Generalized Atherosclerotic Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	

21. I certify that I attended the deceased from **April 1954** to **March 1962** that I last saw the deceased alive on **Dec 13, 1961**, and that death occurred at **2A M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Markleyberg** DATE SIGNED **March 19, 1962**

ACTUAL SIGNATURE Harold O. Kamons	PHYSICIAN'S NAME (Type) HAROLD O. KAMONS		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/18/62	22c. NAME OF CEMETERY OR CREMATORIAL BLOOMING ROSE	22d. LOCATION (City, town, or county) (State) FRIENDSVILLE, GARRETT Co. MD
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Garrettville, Md	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 23 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

1940-301341152

7250

W



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03256

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03250

1. PLACE OF DEATH

a. COUNTY
Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Rural Oakland,

c. LENGTH OF STAY IN 1b

19 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

6 Mi. So. Oakland,

3. NAME OF
DECEASED
(Type or print)

First
Alma

Middle
Fike

Last
Lee

4. DATE
OF
DEATH
March
20th

Month
Year
1962

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED

WIDOWED DIVORCED

8. DATE OF BIRTH

Oct. 6, 1891

9. AGE (in years
last birthday)
70

10. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)
House work

10b. IDB. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (State or foreign country)

Preston Co., W. Va.

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Amelius Fike

14. MOTHER'S MAIDEN NAME

Elizabeth Glass

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

R. Grover Lee R. D. #2, Oakland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Burns, 3rd. degree of entire body

INTERVAL BETWEEN
ONSET AND DEATH
Minutes

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

House caught on fire and occupant did not get out.

20c. TIME OF INJURY Month, Day, Year
Hour e.m. 3-20- 62

20d. INJURY OCCURRED While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)
Residence 20f. (City or town)
Rural, Oakland, Garr. Md. (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DATE SIGNED

ACTUAL
SIGNATURE

EXAMINER'S NAME (Type)
James H. Feaster, Jr., M. D.

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)

Oak., Md. 3-20-62

22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 3/22/1962

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CEMETORY
Eglon Cemetery

ADDRESS

Oakland, Md.

22d. LOCATION (City, town, or country)

(State)

Eglon, Preston Co., W. Va.

24e. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03257

03251

CERTIFICATE OF DEATH

M

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakland,

c. LENGTH OF STAY IN 1b

52 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Cuppett-Weeks Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Lucie

Margaret

Last

4.

DATE
OF
DEATHMarch
7,

19 62

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED

 NEVER MARRIED 8. DATE OF BIRTH DIVORCED

Oct. 2, 1871

9. AGE (In years
last birthday)90
yrs.

10. IF UNDER 1 YEAR

Months

Dey

11. IF UNDER 24 HRS.

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House Work

10b. KIND OF BUSINESS OR INDUSTRY

Own Home

11. BIRTHPLACE (County & State, or foreign country)

Grant County, W. Va.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Daniel M. Tucker

14. MOTHER'S MAIDEN NAME

Elizabeth --?

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or date of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

Vernon Lyon, 181 McDowell

Address

W. Va.

Clarksburg,

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)422
Conditions, if any, which
give rise to immediate cause
(a), stating the underlying
cause last.

DUE TO

(b)

DUE TO

(c)

Congestive Heart Failure
Arteriosclerotic Cardio Vascular Disease 20 yearsINTERVAL BETWEEN
ONSET AND DEATH

5 years

MEDICAL CERTIFICATION

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm,
Hour e.m. While Not While factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
p.m. 19 at work at work 21. I certify that (I) (this hospital) attended the deceased from March 7, 1962, to March 8, 1962, that (I) (we) last
saw the deceased alive on March 7, 1962, and that death occurred 12:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE

22b. DATE
SIGNED

March 8, 1962

Herbert H. Leighton, M.D.

ATTENDING
PHYS. MED.
DIRECTOR STAFF
PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION, DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIAL
REMOVAL (Specify) 23d. LOCATION (City, town or county) (State)
Burial 3/10/1962 Oakland Cemetery Oakland, Maryland.24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
H.C. Leighton Oakland, Md. MAR 12 '62 W. S. KingTO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after
death. If 4 hours are retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should
be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.VR A15 (4)
15M 9/60

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03258

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03252

1. PLACE OF DEATH
a. COUNTY

GARRETT

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

STAR ROUTE, FROSTBURG,

66 Yrs.

c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

H. CAREY

MCMAHON

4. DATE
OF
DEATH

MARCH 7TH, 1962

Month Day Year

5. SEX

6. COLOR OR RACE

MALE

WHITE

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Ret. Bartender

10b. KIND OF BUSINESS OR INDUSTRY

Hotel Bar

8. DATE OF BIRTH

SEPT. 29th, 1894

9. AGE (In years last birthday)

67 yrs.

IF UNDER 1 YEAR
Months Deyrs Hours Min.

13. FATHER'S NAME

HUGH McMAHON

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank and dates of service)

YES

W.W. I

554-14-6474

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

A. LEO McMAHON, CRESAPTON, MD.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420

DOUE TO

(b)

DOUE TO

(c)

Coronary Occlusion
Coronary Sclerosis
Pericarditis

INTERVAL BETWEEN
ONSET AND DEATH

1 hr

?

?

?

19. WAS AUTOPSY PERFORMED? (Yes or No)

YES NO

20e. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH

2db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour e.m. While Not White
p.m. 19 at work at work

20d. INJURY OCCURRED
While Not White
at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL
SIGNATURE

W. O. McLane

CHIEF MEDICAL EXAMINER

M.D. ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED
3-7-62

Address (Street, city, town, or county)

167 E. MAIN ST.,
FROSTBURG, MD.

(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

3-10-62

22c. NAME OF CEMETERY OR CREMATORI

ST. MICHAELS CEMETERY FROSTBURG,

22d. LOCATION (City, town, or country)

MD.

23. FUNERAL DIRECTOR

J. P. Durst

ADDRESS

FROSTBURG, MD.

24e. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

MAR 12 '62

DATE

Caroline S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 9/60

50520

M

4

10

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03259

CERTIFICATE OF DEATH

03253

1. PLACE OF DEATH

a. COUNTY
Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Mt. Lake Park,

c. LENGTH OF STAY IN lb

4 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

March 28,

19 62

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

Male

White

WIDOWED

DIVORCED

June 27, 1880

9. AGE (In years
last birthday)
81 yrs.

IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Retired Coal Miner Soft coal

Allegany Co., Md.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

Charles Miller

Mary Ann Johnson

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service)

no

16. SOCIAL SECURITY NO.

17. INFORMANT

191-03-6567

Mrs. Mildred Miller Mb. Lake Park, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

442
DUE TO
Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Armenia

arteriosclerotic Cardiorenal Disease 57/20

INTERVAL BETWEEN
ONSET AND DEATH
7 days

Arteriosclerosis

10/22

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 4/4/1955 to 3/28/1962, that (I) (we) last saw the deceased alive on 3/27/1962, and that death occurred 5:00A from the causes and on the date stated above.

22a. SIGNATURE

A. E. Mance

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
2/8/1962

22c. PHYSICIAN'S
NAME (Type)

A. E. Mance, M.D.

22d. ADDRESS

Oakland, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial

23b. DATE THEREOF
3/30/1962

23c. NAME OF CEMETERY OR CREMATORI

Paradise Church Cemetery Garrett Co., Md.

23d. LOCATION (City, town or county)

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

H. C. Leighton

ADDRESS

Oakland, Md.

25a. REC'D BY REGISTRAR

APR 2 '62

25b. REGISTRAR'S SIGNATURE

Arthur S. Mance

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03250 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03254

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G310 4/2/62 mh

CERTIFICATE OF DEATH

Reg. Dist. 03255

03261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Garrett		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Grantsville		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mintie Durst Platter		First Mintie	Middle Durst	Last Platter	4. DATE OF DEATH March 25 1962	Month March	Day 25	Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH June 11, 1895	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 66 1/2	10. IF UNDER 1 YEAR Months 66	11. IF UNDER 24 HRS. Hours 1/2	12. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own. home		11. BIRTHPLACE (State or foreign country) Grantsville, Md.		14. MOTHER'S MAIDEN NAME Catherine Bittinger			
13. FATHER'S NAME Eli Durst		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1		INFORMANT Irvin Platter, Grantsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 1 hour							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X		Acute brain syndrome							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. 443 X		DUE TO Hypertension							
		DUE TO arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Chronic myopathy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Grantsville	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from 7-15 1948 to 3-17 1962 , that I last saw the deceased alive on 3-17 1962 , and that death occurred at 6 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Meyersdale, Pa						DATE SIGNED 3-26-62	
ACTUAL SIGNATURE <i>Garrett Durst M.D.</i>									
PHYSICIAN'S NAME (Type) Covant & Fawcett									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-1962		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Durst Cemetery		22d. LOCATION (City, town, or county) Grantsville, Garrett, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don Newman, Grantsville, Md.</i>		24a. REC'D BY REGISTRAR Mar 28 '62						24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03262

03256

1. PLACE OF DEATH

a. COUNTY

Garrett

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Oakland, Md.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Garrett County Memorial Hospital

3. NAME OF DECEASED
(Type or print)First Middle
William James Sheets

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Garrett

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Deer Park, Maryland

d. STREET ADDRESS

e. IS RESIDENCE
ON A FARM?YES NO

5. SEX

m

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED X

8. DATE OF BIRTH

4-26-1897

9. AGE (In years
last birthday)

64

yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

12. DAY

Hours

13. MONTH

Min.

3 1 19 62

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Construction Worker Machine Operator

11b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

Cannonsburg, Pa.

12. CITIZEN OF WHAT COUNTRY?

United States

13. FATHER'S NAME

Sheets, James William

14. MOTHER'S MAIDEN NAME

Mc Cartney, Anna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

no

16. SOCIAL SECURITY NO.

193-07-9086

17. INFORMANT

Edward Sheets

Address

Deer Park, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

Congestive Heart failure

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a.m.

Whila

p.m.

Not While

at work

at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from.....

1-20

1962

to 3-1-1962

saw the deceased alive on.....

3-1-

1962

and that death occurred at

9:50 A.M.

from the causes and on the date stated above.

22a. SIGNATURE

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

Dr. E. I. Baumgartner

22d. ADDRESS

Oakland, Maryland

3/1/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/3/1962

23c. NAME OF CEMETERY OR CREMATORIUM

Mt. Zion Cemetery

23d. LOCATION (City, town or county)

Garrett County, Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

J.C. Reighlon

ADDRESS

Oakland, Md.

25a. REC'D. BY REGISTRAR

MAR 5 1962

25b. REGISTRAR'S SIGNATURE

John S. Thrall

DATE

SILVER BIRCH 380-10-15

10

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03263

03257

1. PLACE OF DEATH a. COUNTY Garrett		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park		c. LENGTH OF STAY IN 1b 6 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) L St. & Oakland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		First Victoria	Middle Tasker
4. DATE OF DEATH March 29, 1962	Month March	Day 29	Year 1962
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 25, 1871		9. AGE (In years lost birthday) 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Deer Park, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Paugh	
14. MOTHER'S MAIDEN NAME Isabelle Enlow		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Ethel Davies Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Gastritis Serum al Arterio sclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/29, 1961, to 3/29, 1962, that (I) (we) last saw the deceased alive on 3/27, 1962, and that death occurred at 6:30 A.M., from the causes and on the date stated above.		22a. SIGNATURE Andrew E. Mance	
22b. DATE SIGNED 30 Mar 62		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Andrew E. Mance		22d. ADDRESS 3 rd. St. Oakland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/31/62	
23c. NAME OF CEMETERY OR CREMATORIAL Tasker Cemetery		23d. LOCATION (City, town, or county) (State) Garrett Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE, Gerald N. Minnich		ADDRESS Oakland, Maryland	
25a. REC'D BY REGISTRAR DATE APR 5 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Hansen	

22550

HANCOCK TRADE RECORD

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03264

03258

1. PLACE OF DEATH a. COUNTY <i>Garrett</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Allegany</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oakland</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Corrigansville</i>		d. STREET ADDRESS <i>61X-2</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Weeks-Cuppett Nursing Home</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Martha</i>		First <i>Martha</i>	Middle <i>Elizabeth</i>	Last <i>Urice</i>	4. DATE OF DEATH <i>March 16, 1962</i>	Month <i>March</i>	Day <i>16</i>	Year <i>1962</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 22, 1883</i>		9. AGE (In years (In birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Romney, West Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>James Gano</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Urice Corrigansville, Md.</i>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Keyser</i>	(County) <i>West Va</i>	(State) <i>W. Va</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>April 21 1961</i> to <i>March 16 1962</i> , that (I) (we) last saw the deceased alive on <i>March 3 1962</i> and that death occurred at <i>M</i> , from the causes and on the date stated above.								22b. DATE SIGNED <i>2/18/62</i>			
22a. SIGNATURE <i>Ed. B. Bingham</i>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME <i>E. B. Bingham</i>		22d. ADDRESS <i>25 Cedar St. Danville, Va</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 20, 1962</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cabin Run Cemetery</i>		23d. LOCATION (City, town, or county) <i>Keyser, West Va</i>		(State) <i>W. Va</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. K. Chambers</i>		ADDRESS <i>Keyser, West Va</i>		25a. REC'D BY REGISTRAR <i>Arthur L. Krause</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Krause</i>					

may be rendered by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03259

03265		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
1. PLACE OF DEATH a. COUNTY Garrett		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN 1b 3 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cuppett Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park X	
3. NAME OF DECEASED (Type or print) Bertha		First	Middle
			Warnick
4. DATE OF DEATH		Month	Day
		Mar. 31,	1962
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Aug. 30, 1884	
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Rest. Business	11. BIRTHPLACE (State or foreign country) New Germany, Md.
13. FATHER'S NAME Ashford Warnick		14. MOTHER'S MAIDEN NAME Iantha Michaels	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT A. C. Warnick
		Address Oakland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
420 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
DUE TO (b) Myocardial Infarction DUE TO (c) Atherosclerotic CU Disease.			
INTERVAL BETWEEN ONSET AND DEATH 12 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Chronic bronchitis & emphysema			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 22 Nov 1960 to 31 Mar 1961, that (I) (we) last saw the deceased alive on 31 Mar 1962 and that death occurred at 7:30 AM, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE B. L. Grant		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS 77 Third St. Oakland, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/3/62	23c. NAME OF CEMETERY OR CREMATORIAL Oakland Cemetery
24. FUNERAL DIRECTOR'S SIGNATURE Gerald N. Minich		ADDRESS Oakland, Maryland	23d. LOCATION (City, town, or county) Oakland, Maryland (State)
			25a. REC'D BY REGISTRAR APR 9 '62 DATE
			25b. REGISTRAR'S SIGNATURE Curtis J. Minich

2025 RELEASE UNDER E.O. 14176

7480 3108 002

2025

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1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours are not available, the physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be retained by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 0 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03266

03260

1. PLACE OF DEATH
e. COUNTY

GARRETT

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

OAKLAND

c. LENGTH OF STAY IN 1b

14 hrs. 55 min. X SWANTON

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

GARRETT COUNTY MEMORIAL HOSPITAL

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

MARCH

21 1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

MARCH 20, 1962

9. AGE (In years
last birthday)
yrs.

IF UNDER 1 YEAR
Months Days Hours Min.
14
55

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

HOMER WILT

14. MOTHER'S MAIDEN NAME

KNOX, BERTHA ANNABEL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give rank or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

FATHER-WILT HOMER SWANTON, MARYLAND

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY;
IMMEDIATE CAUSE (e)

773

5

DUE TO

Conditions, if any, which
give rise to immediate cause
(e), stating the underlying
cause last.

(b)

DUE TO

(c)

Respiratory Inadequacy
Premature Delivery (months)

INTERVAL BETWEEN
ONSET AND DEATH

15 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e). 19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.

20d. INJURY OCCURRED
While Not While
at work at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from MARCH 20, 1962 to MARCH 21, 1962, that (I) (we) last
saw the deceased alive on MARCH 21, 1962, and that death occurred at 2:55 p.m. The causes and on the date stated above.

22a. SIGNATURE

H. Leighton

M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED

21 Mar 62

22c. PHYSICIAN'S
NAME (Type)

DR. H. LEIGHTON

22d. ADDRESS

OAKLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/23/1962

23c. NAME OF CEMETERY OR CREMATORIUM

Fitzwater Cemetery

23d. LOCATION (City, town or county)

(State)

near Swanton, Md.

24. FUNERAL DIRECTOR'S SIGNATURE

H. Leighton

ADDRESS

Oakland, Md.

25e. REC'D BY REGISTRAR

DATE MAR 27 '62

25f. REGISTRAR'S SIGNATURE

Arthur S. Krause

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